

**King County
Work & Life Benefits
Medical Plan Summaries
PacifiCare Choice Plan
and
PacifiCare Health Management Option**

[this cover will be replaced by artwork]

**Final (revised)
December 17, 1999**

Directory

If you have questions about ...	Contact ...
<ul style="list-style-type: none"> • Benefits eligibility • Enrollment • When coverage begins • Other King County Work & Life Benefits 	<p>Benefits & Well-Being at 206-684-1556 (8:30 a.m. – 4:30 p.m. Monday – Friday, except 10:30 a.m. – 4:30 p.m. Thursday)</p> <p>www.metrokc.gov/ohrm/benefits</p> <p>Exchange Building Mail Stop EXC-HR-1030 821 Second Avenue Seattle WA 98104-1598</p>
<ul style="list-style-type: none"> • Providers (primary care physicians, hospitals, etc.) • Changing your primary care physician • Filing claims • Preauthorization for certain care (see “Obtaining Preauthorization” for details) • Other plan details (covered expenses, limitations, exclusions, out-of-area coverage, specific medical conditions or treatment, etc.) 	<p>PacifiCare at 1-800-932-3004 (7 a.m. – 6:30 p.m. Monday – Friday)</p> <p>www.pacificare.com</p> <p>PO Box 3005 Hillsboro OR 97123</p>
<ul style="list-style-type: none"> • Preauthorization for mental health and chemical dependency treatment 	<p>PacifiCare Behavioral Health at 1-800-577-7244 (24 hours a day, 7 days a week)</p> <p>King County’s Making Life Easier Program at 1-888-874-7290 (24 hours a day, 7 days a week)</p>
<ul style="list-style-type: none"> • Registration for PacifiCare’s Stop Smoking Program 	<p>PacifiCare’s Health Improvement Line at 1-800-513-5131 (8:30 a.m. – 5 p.m. Monday – Friday)</p>



*The information in this booklet is available in accessible
formats by calling Benefits and Well-Being at 206-684-1556 (voice)
or through Washington State Telecommunication
Relay Service at 1-800-833-6388.*



Although this booklet includes certain key features and brief summaries of this medical coverage, it does not provide detailed descriptions. If you have specific questions, contact PacifiCare or Benefits and Well-Being.

We’ve made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between this booklet and the insurance contracts or other legal documents, the legal documents will always govern.

King County intends to continue these plans indefinitely but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents.

This booklet does not create a contract of employment with King County.

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Highlights

Here are a few highlights of your coverage under the PacifiCare Choice Plan and PacifiCare Health Management Option:

- You do not pay an annual deductible under these plans (unless you are eligible for either plan's out-of-area benefits; see "If You Live Outside the Service Area" on page 10 or page 15 for details).
- You pay a copay for office visits under these plans.
- The *PacifiCare Choice Plan* offers 2 levels of benefits: PCP-directed benefits (generally paid at 100%) and self-directed benefits (generally paid at 60%). You have the choice between these levels of benefits each time you need care. Your decision to contact, or not to contact, your primary care provider (PCP) for your care determines the level of benefits you receive.
- The *PacifiCare Health Management Option* offers PCP-directed benefits (generally paid at 100%), which means – in most cases – you must see your primary care provider for care.

Important Facts

This booklet describes the PacificCare medical plans. However, there are many important topics including laws, regulations and county provisions that affect more than just these plans. These provisions can change frequently. To be more efficient, and avoid repetition, we included the following topics in your "Important Facts" booklet:

- What Happens If (you take a leave of absence, become disabled, etc.)
- Eligibility
- Enrolling in the Plans
- When Coverage Begins
- Qualified Medical Child Support Order (QMCSO)
- When Coverage Ends
- Continuation of Coverage (COBRA)
- Assignment of Benefits
- Third Party Claims
- Recovery of Overpayments
- Termination and Amendment of the Plans
- Medical Plan Participant Bill of Rights.

Who's Eligible

Refer to your "Important Facts" booklet for information about eligibility and appeal of eligibility.

Cost

When you receive medical care, you pay:

- Required copays, paid at the time of the service
- Coinsurance amounts not covered by the plans
- Amounts in excess of the usual, customary and reasonable (UCR) amounts (see page 44 for a definition)
- Expenses for services or supplies not covered by the plans.

See “Medical Plan Summary” starting on page 3 (PacifiCare Choice Plan) or page 11 (PacifiCare Health Management Option) for more information on copays and coinsurance amounts. See your enrollment materials for information related to any monthly cost of coverage.

Enrolling in the Plans

If you are a newly hired employee, you must submit a completed enrollment form to Benefits and Well-Being within 30 days of your hire date; otherwise, you will receive default coverage. See your enrollment materials for details.

Making Changes

Each year during open enrollment, you may change your elections. Under certain circumstances, you may make changes during the year. Refer to your “Important Facts” booklet for details.

When Coverage Begins

Refer to your “Important Facts” booklet for information on when coverage begins.

Preexisting Condition Limit

These plans do not have a preexisting condition limit. However, there is a waiting period for transplants, see page 29 for more information. If you end employment with King County, please refer to page 38 for information on how your participation in these plans could be credited against another plan with a preexisting condition limit.

How the PacifiCare Choice Plan Works

Medical Plan Summary

The following table summarizes covered services and supplies under the PacifiCare Choice Plan and identifies related coinsurance, copays, maximums and limitations. Please refer to “Covered Expenses” and “Expenses Not Covered” for more information on your medical benefits. Only medically necessary services and supplies are covered. Throughout this table, PCP means primary care provider.

	PacifiCare Choice Plan		For more information refer to ...
	PCP-Directed	Self-Directed	
Annual deductible	None	None	–
Annual out-of-pocket maximum	None	\$1,600/person (no family maximum)	Page 6
Lifetime maximum	\$2,000,000 ^❶		Page 6
Covered Expenses	Plan Pays		
Alternative care (certain services only)	100%, after \$10 copay/visit	100%, after \$20 copay/visit	Page 17
Ambulance services	80%	80%	Page 17
Chemical dependency treatment (up to \$10,000 in plan payments in 24 consecutive months)	100% ^❷ (Behavioral Health must refer you)	60% ^❸	Page 17
Chiropractic care (up to 33 self-directed visits/year – network and non-network combined)	100%, after \$10 copay/visit	Network provider: 100%, after \$10 copay/visit Non-network provider: 100%, after \$20 copay/visit	Page 18
Diabetes care training	100%	Not covered	Page 18
Durable medical equipment and prosthetics	80%	50% ^❸	Page 18
Emergency care (in an emergency room) - Emergency care - Nonemergency care	100% after \$50 copay/visit (waived if admitted) 100% after \$50 copay/visit (waived if admitted)	100% after \$50 copay/visit ^❸ (waived if admitted) 60% after \$50 copay/visit ^❸ (waived if admitted)	Page 19

❶ The maximum applies to all care received, whether PCP-directed or self-directed.

❷ You must obtain preauthorization through PacifiCare Behavioral Health. See page 9 for details.

❸ You must obtain preauthorization for your care (or authorization after you are admitted because of an emergency). See page 9 for details.

PacifiCare Choice Plan

Covered Expenses	PacifiCare Choice Plan		For more information refer to ...
	PCP-Directed	Self-Directed	
Family planning	100%	100% after \$20 copay/visit	Page 19
Growth hormones	Not covered	Not covered	—
Hearing aids (up to \$500/3-year period)	100%	Not covered	Page 19
Home health care (up to 130 visits/year) ❶	100%	75%❸	Page 19
Hospice care (up to 6 months lifetime) ❶	100%	75%❸	Page 20
Hospital care (inpatient and outpatient)	100%	60%❸	Page 21
Infertility	Not covered	Not covered	Page 21
Injury to teeth	100%	100%	Page 21
Inpatient care alternatives	100%	60%❸	Page 22
Lab, x-ray and other diagnostic testing (includes mammograms, prenatal tests)	100%	100%	Page 22
Maternity care	100% after \$10 copay/pregnancy	60% after \$10 copay/pregnancy	Page 22
Mental health care - Inpatient (up to 30 days/year) ❶ - Residential and day treatment (also subject to inpatient maximum; each day of care counts as half an inpatient day) ❶ - Outpatient	(Behavioral Health must refer you) 100%❷ 100%❷ 50% up to 52 visits per year❷	60%❸ 60%❸ 50% up to 9 visits per year❸	Page 23
Neurodevelopmental therapy - Inpatient (up to \$30,000/condition/year) ❶ - Outpatient (up to 60 visits/year) ❶	100% 100% after \$10 copay/visit	60%❸ 60%	Page 24
Newborn care	100%	Benefit level will vary depending on services provided	Page 24
Physician and other medical and surgical services	100% after \$10 copay/visit	100% after \$20 copay/visit	Page 24
PKU formula	80%	60%	Page 24

❶ The maximum applies to all care received, whether PCP-directed or self-directed.

❷ You must obtain preauthorization through PacifiCare Behavioral Health. See page 9 for details.

❸ You must obtain preauthorization for your care (or authorization after you are admitted because of an emergency). See page 9 for details.

PacifiCare Choice Plan

Covered Expenses	PacifiCare Choice Plan		For more information refer to ...
	PCP-Directed	Self-Directed	
Prescription drugs - Network pharmacy (up to 30-day supply) ♦ Generic drugs and insulin ♦ Brand-name drugs (covered only when generic not available) - Mail order (up to 90-day supply)	100% after \$5 copay/prescription or refill 100% after \$10 copay/prescription or refill 100% after \$10 copay/prescription	100% after \$5 copay/prescription or refill ❹ 100% after \$10 copay/prescription or refill ❹ 100% after \$10 copay/prescription ❹	Page 25
Preventive care (exams and immunizations)	100% after \$10 copay/visit	Not covered	Page 26
Radiation therapy, chemotherapy and respiratory therapy	100%	60%	Page 27
Reconstructive services	100%	60%	Page 28
Rehabilitative services - Inpatient (up to \$30,000/condition) ❶ - Outpatient (up to 60 visits/year) ❶	100% 100% after \$10 copay/visit	60% ❸ 60%	Page 28
Skilled nursing facility (up to 100 days/year) ❶	100%	60% ❸	Page 29
Stop Smoking Program	100% after \$20 copay for program 100% after \$20 copay one 4-week supply of nicotine replacement therapy	100% after \$20 copay for program 100% after \$20 copay one 4-week supply of nicotine replacement therapy	Page 27
TMJ (up to \$1,000/year; \$5,000 lifetime maximum)	50%	Not covered	Page 29
Transplants (certain transplants only)	100%	Not covered	Page 29
Urgent care	100% after \$10 copay/visit	100% after \$20 copay/visit	Page 31

❶ The benefit maximum applies to all care, whether PCP-directed or self-directed.

❸ You must obtain preauthorization for your care. See page 9 for details.

❹ You must obtain preauthorization for certain drugs. See page 9 for details.

PacifiCare Choice Plan

How the Plan Pays Benefits

The following chart shows how benefits are determined for most covered expenses.

Plan Feature	PacifiCare Choice Plan
You pay copays if you need prescription drugs or emergency room care.	See "Medical Plan Summary" for amounts
After the copays, the plan pays the next \$4,000 of most covered expenses at this level ...	100% PCP-directed 60% self-directed
Then, the balance of most expenses for the year is paid at ...	100%

Annual Out-of-Pocket Maximum

There is no out-of-pocket maximum for PCP-directed care because most services are already covered at 100%. The out-of-pocket maximum for self-directed care is \$1,600 per person (there is no family maximum).

The out-of-pocket maximum is generally the most you pay toward most copays and coinsurance each plan year. This means once you reach your out-of-pocket maximum, the plan pays 100% of most covered expenses for the rest of the year. Each participant has a separate out-of-pocket maximum.

The following do not apply to the out-of-pocket maximum:

- Copays for prescription drugs and chiropractic treatment
- Any charges that exceed UCR amounts or benefit maximums
- Services or supplies not covered by the plan
- Coinsurance for mental health care
- Coinsurance amounts for self-directed chiropractor visits.

Lifetime Maximum

Benefits under the PacifiCare Choice Plan and all prior PacifiCare plans are limited to \$2,000,000 for all health care combined during your lifetime. However, at the start of the plan year, up to \$10,000 of the amount subtracted from the maximum and not added back in a previous year will go back into your lifetime maximum.

The Network

To be considered for the network, all hospitals must be accredited by the Joint Commission on Accreditation of Health Care Organizations and have a current state license as well as adequate liability insurance. Doctors or other health care professionals must also complete a detailed application to be considered for the network. The application covers education, status of board certification, malpractice and state sanction histories. All providers – hospitals, clinics, doctors and other health care professionals who make up the network – are carefully screened by PacifiCare.

Selecting a Primary Care Provider (PCP)

Your primary care provider is your personal doctor and the starting point for all your medical care. PCPs can be family or general practitioners, internists or pediatricians. If you need a specialist, your primary care provider will arrange it. To receive the highest level of benefits, your primary care provider must provide or coordinate your care. There are a few exceptions; see “Accessing Care” on page 8.

You must select a primary care provider when you enroll; otherwise, one will be chosen for you. Each family member may have a different primary care provider. Refer to the PacifiCare provider directory for a list of primary care providers. The directory is updated periodically; for a current list of providers, contact the plan directly. The name of your primary care provider is printed on your ID card.

Continuity of your care is important – and easier to achieve if you establish a long-term relationship with your primary care provider. However, you may find it necessary to change your primary care provider.

Before you see another primary care provider, you must call PacifiCare at 1-800-932-3004. You may see your new primary care provider following PacifiCare’s approval of your request – requests for changes received before the 15th of the month take effect the first of the next month.

Primary Hospitals

When you choose a primary care provider, you are also choosing a hospital that will provide most of the hospital services you need (called a “primary hospital”). Your PacifiCare provider directory lists each physician and the hospital with which he or she is affiliated.

Specialists

If you want to receive PCP-directed benefits, you must receive a referral from your primary care provider before you see a specialist. If you see a specialist without a referral, you receive self-directed benefits as described in “Medical Plan Summary” starting on page 3. There are a few exceptions, see “Accessing Care” on page 8.

Your primary care provider has agreed to refer you only to specialists who:

- Are licensed, certified or registered, as required by the state
- Are affiliated with your primary care provider’s medical group (most primary care providers are members of large medical groups made up of multiple specialty providers and facilities)
- Are affiliated with your primary hospital; you are responsible for confirming that you’re being referred to a specialist affiliated with your primary hospital (contact PacifiCare to confirm this).

If you have an unusual medical condition, you may need to see a specialist who is not affiliated with your primary hospital or medical group.

When you are referred, be sure to get a referral form from your primary care provider and take it to the specialist. The referral will state the number of visits and/or type of treatment to be provided by the specialist. Expired referrals must be renewed by the primary care provider if additional specialist care is required. Maternity care referrals are valid for the term of the pregnancy and the first 8 weeks thereafter.

Sometimes a specialist wants you to see another specialist. If so, you must check with your primary care provider, who will determine if the second referral is medically necessary.

PacifiCare Choice Plan

Accessing Care

You may take advantage of either PCP directed benefits or self-directed benefits; the level of benefits you receive depends on the provider you see.

- PCP-directed benefits are payable when your primary care provider (PCP) provides or coordinates your care
- Self-directed benefits are payable when you receive covered expenses from other licensed providers (network or non-network providers).

“Primary care provider,” “network provider” and “non-network provider” are defined in “Definitions” starting on page 40.

To receive PCP-directed benefits:

- You make an appointment with your primary care provider
- You pay the \$10 office visit copay at the time you receive health care services
- Your primary care provider will obtain preauthorization for your care as necessary
- The plan pays 100% for most covered services
- The plan handles all forms and paperwork.

For chemical dependency treatment or mental health care: You also may call King County’s Making Life Easier Program at 1-888-874-7290. Staff will obtain preauthorization as necessary and refer you to a provider for treatment.

You may see any provider in an emergency. However, to receive most PCP-directed benefits, you must see or call your primary care provider first. Here are a few exceptions; you may receive these services from a *network provider* – without a referral from your primary care provider – and still receive PCP-directed benefits:

- Chiropractic care (maximum 33 visits a year)
- Chemical dependency treatment (must be preauthorized by PacifiCare Behavioral Health)
- Mental health care (must be preauthorized by PacifiCare Behavioral Health)
- Urgent care
- Women’s health care services (for example, maternity care, reproductive health services and gynecological care).

Call PacifiCare for information on network providers. Depending on the service (for example, if you need surgery), you may need to obtain preauthorization for your care; see page 15 for details.

To receive self-directed benefits:

- You make an appointment with a licensed provider recognized by this plan (see page 42 for a definition of licensed providers)
- You pay the \$20 office visit copay at the time you receive health care services
- You must obtain preauthorization for certain procedures and services as described in “Obtaining Preauthorization”
- The plan pays 60% for most covered services
- If you see a network provider, the plan handles all forms and paperwork; if you see a non-network provider, you must pay the bill in full and file a claim for reimbursement
- Your provider bills you for any balance you may owe after plan payments; you are responsible for any charges that exceed UCR amounts (see page 44 for a definition).

Second Opinions

On occasion, you may want a second opinion. To receive PCP-level benefits, you must get a referral from your primary care provider. At any point, you may decide to see any licensed physician (other than your primary care provider) and receive self-directed benefits.

Obtaining Preauthorization

Preauthorization means approval of a service, supply or drug before you receive it. Your primary care provider will work with PacifiCare to obtain preauthorization for your care as necessary.

You are responsible for obtaining preauthorization for certain services if you self-direct your care. This means you must ask your physician to call and obtain preauthorization on your behalf. You may then call PacifiCare at 1-800-932-3004 to check that he or she followed through.

If you obtain preauthorization, benefits will be paid according to plan provisions and limitations. It's possible benefits would not be paid if, for example, you aren't eligible for coverage on the day you receive the service.

When to Call: If you self-direct your care, you must obtain preauthorization for these covered supplies or services:

- Chemical dependency treatment
- Durable medical equipment
- Home health care
- Hospice care
- Hospitalizations (including labor and delivery, except for hospital stays of 48 hours or less for normal vaginal delivery or 96 hours for cesarean section)
- Inpatient care alternatives
- Mental health care
- Skilled nursing facility
- Surgeries.

If you are having surgery or being admitted to a hospital, skilled nursing facility, hospice or home health agency, notify PacifiCare as soon as possible – and in any case, at least 12 hours before the surgery or admission.

You do not need preauthorization for:

- Accidents (see page 40 for a definition)
- Emergencies (including detoxification)
- Hospital stays of 48 hours or less for normal vaginal delivery or 96 hours for cesarean section.

However, you (or a family member or hospital staff member) are expected to call within 24 hours from the start of your care (48 hours for mental health care or chemical dependency treatment).

For mental health care or chemical dependency treatment: You also may call King County's Making Life Easier Program at 1-888-874-7290. Staff will obtain preauthorization for your care and refer you to a provider for treatment.

How to Call: To obtain preauthorization for care other than mental health care and chemical dependency treatment, have your physician call PacifiCare at 1-800-932-3004, 7:00 a.m. to 6:30 p.m. Pacific time, Monday - Friday.

To obtain preauthorization for *mental health care* and *chemical dependency treatment*, you or your physician must call PacifiCare Behavioral Health at 1-800-577-7244, 24 hours a day, 7 days a week.

PacifiCare Choice Plan

Obtaining Preauthorization (cont'd)

When calling PacifiCare Behavioral Health, be prepared to provide the following information:

- Your name
- Group number and member number (on your ID card)
- The reason for your call.

If You Don't Call: If your care is not preauthorized as described above, your care will not be covered.

If You Live Outside the Service Area

You are eligible for out-of-area benefits if you live outside PacifiCare's service area and more than 30 miles away from the nearest available primary care provider for at least 9 months out of each year. Call PacifiCare for information on service areas.

Here's how the out-of-area plan works:

- You pay a \$200 per person, \$600 per family, annual deductible (the deductible doesn't apply to prescription drugs)
- You make an appointment with a licensed provider (see page 42 for a definition)
- The plan pays 80% for most covered services; if you reach your \$1,000 per person (\$2,000 per family) out-of-pocket maximum, the plan pays 100% for most covered expenses for the rest of the year
- You must obtain preauthorization for certain procedures and services, as described in "Obtaining Preauthorization" starting on page 9
- Depending on your provider, you may have to pay the bill in full and file a claim for reimbursement
- You are responsible for any charges that exceed UCR amounts (see page 44 for a definition).

Also see "If Your Family Member Lives Away From Home" on page 34.

Mental Health Care and Chemical Dependency Treatment: Out-of-area participants do not need to see a PacifiCare Behavioral Health provider for mental health care or chemical dependency treatment (but you or your physician will need to obtain preauthorization for your care by calling PacifiCare Behavioral Health at 1-800-577-7244).

Prescription Drugs: You don't need to fill your prescriptions at a network pharmacy to receive benefits. Pay for the prescription in full and file a claim for a reimbursement. The plan pays 100% minus your copay (if any) per prescription.

How the PacifiCare Health Management Option Works

Medical Plan Summary

The PacifiCare Health Management Option offers PCP-directed benefits only. This means the plan pays benefits for services provided or coordinated by your primary care provider. (See “Accessing Care” on page 14 for exceptions to this provision.)

The following table summarizes covered services and supplies under this plan and identifies related coinsurance, copays, maximums and limitations. Please refer to “Covered Expenses” and “Expenses Not Covered” for more information on your medical benefits. Only medically necessary services and supplies are covered.

	PacifiCare Health Management Option	For more information refer to...
Annual deductible	None	–
Annual out-of-pocket maximum	None	–
Lifetime maximum	None	–
Covered Expenses	Plan Pays	
Alternative care (certain services only)	100% after \$10 copay/visit	Page 17
Ambulance services	100%	Page 17
Chemical dependency treatment ^❶ (up to \$10,000 in plan payments in 24 consecutive months)	100% (Behavioral Health must refer you)	Page 17
Chiropractic care (you may also see a network provider for chiropractic care, without a referral from your primary care provider, for up to 33 visits)	100% after \$10 copay/visit	Page 18
Diabetic care training	100%	Page 18
Durable medical equipment and prosthetics	100%	Page 18
Emergency care ^❷ (in an emergency room) - Emergency care - Nonemergency care not PCP-directed	100% after \$50 copay/visit (waived if admitted) Not covered	Page 19
Family planning	100%	Page 19
Growth hormones	Not covered	–
Hearing aids (up to \$500 every 36 months)	100%	Page 19
Home health care (up to 130 visits/year)	100%	Page 19
Hospice care (up to 6 months lifetime)	100%	Page 20
Hospital care (inpatient and outpatient)	100%	Page 21

❶ You must obtain preauthorization through PacifiCare Behavioral Health. See page 15 for details.

❷ If your primary care provider doesn't provide or coordinate this care, you must obtain preauthorization (or authorization after you are admitted because of an emergency). See page 15 for details.

PacifiCare Health Management Option

Covered Expenses	PacifiCare Health Management Option	For more information refer to...
Infertility	Not covered	Page 21
Injury to teeth	100%	Page 21
Inpatient care alternatives	100%	Page 22
Lab, x-ray and other diagnostic testing (includes mammograms, prenatal tests)	100%	Page 22
Maternity care	100% after \$10 copay/pregnancy	Page 22
Mental health care^❶ - Inpatient (up to 30 days/year) - Residential and day treatment (also subject to inpatient maximum; each day of care counts as half an inpatient day) - Outpatient	(Behavioral Health must refer you) 100% 100% 100% after \$10 copay/visit, up to 30 visits/year	Page 23
Neurodevelopmental therapy - Inpatient - Outpatient	100% 100% after \$10 copay/visit, up to 60 visits/year	Page 24
Newborn care	100%	Page 24
Physician and other medical and surgical services	100% after \$10 copay/visit	Page 24
PKU formula	100%	Page 24
Prescription drugs - Network pharmacy (up to 30-day supply) <ul style="list-style-type: none"> ◆ Generic drugs and insulin ◆ Brand-name drugs (covered only when generic not available) - Mail order (up to 90-day supply)	100% after \$5 copay/prescription 100% after \$10 copay/prescription or refill 100% after \$10 copay/prescription	Page 25
Preventive care (exams and immunizations)	100% after \$10 copay/visit	Page 26
Radiation therapy, chemotherapy and respiratory therapy	100%	Page 27
Reconstructive services	100%	Page 28
Rehabilitative services - Inpatient - Outpatient	100% up to 60 days/condition 100% after \$10 copay/visit, up to 60 visits/year	Page 28
Skilled nursing facility	100% up to 100 days/year	Page 29
Stop Smoking Program	100% after \$20 copay	Page 27
TMJ (up to \$1,000/year; \$5,000 lifetime maximum)	50%	Page 29
Transplants (certain transplants only)	100%	Page 29
Urgent care	100% after \$10 copay/visit	Page 31

❶ You must obtain preauthorization through PacifiCare Behavioral Health. See page 15 for details.

How the Plan Pays Benefits

The following chart shows how benefits are determined for most covered expenses.

Plan Feature	PacifiCare Health Management Option
You pay copays for office visits, prescription drugs or emergency room care.	See “Medical Plan Summary” for amounts
After the copays, the plan pays for most covered services at this level ...	100%

The Network

To be considered for the network, all hospitals must be accredited by the Joint Commission on Accreditation of Health Care Organizations and have a current state license as well as adequate liability insurance. Doctors or other health care professionals must also complete a detailed application to be considered for the network. The application covers education, status of board certification, malpractice and state sanction histories. All providers – hospitals, clinics, doctors and other health care professionals who make up the network – are carefully screened by PacifiCare.

Selecting a Primary Care Provider (PCP)

Your primary care provider is your personal doctor and the starting point for all your medical care. PCPs can be family or general practitioners, internists or pediatricians. If you need a specialist, your primary care provider will arrange it. To receive benefits, your primary care provider must provide or coordinate your care. There are a few exceptions; see “Accessing Care” on page 14.

You must select a primary care provider when you enroll; otherwise one will be chosen for you. Each family member may have a different primary care provider. Refer to the PacifiCare provider directory for a list of primary care providers. The directory is updated periodically; for a current list of providers, contact the plan directly. The name of your primary care provider is printed on your ID card.

Continuity of your care is important – and easier to achieve if you establish a long-term relationship with your primary care provider. However, you may find it necessary to change your primary care provider.

Before you see another primary care provider, you must call PacifiCare at 1-800-932-3004. Requests for changes received before the 15th of the month take effect the first of the next month. You may see your new primary care provider the first of the month following PacifiCare’s approval of your request.

Primary Hospitals

When you choose a primary care provider, you are also choosing a hospital that will provide most of the hospital services you need (called a “primary hospital”). Your PacifiCare provider directory lists each physician and the hospital with which he or she is affiliated.

PacifiCare Health Management Option

Specialists

To receive benefits, you must receive a referral from your primary care provider before you see a specialist. Your primary care provider has agreed to refer you only to specialists who:

- Are licensed, certified or registered, as required by the state
- Are affiliated with your primary care provider's medical group (most primary care providers are members of large medical groups made up of multiple specialty providers and facilities)
- Are affiliated with your primary hospital; you are responsible for confirming that you're being referred to a specialist affiliated with your primary hospital (contact PacifiCare to confirm this).

If you have an unusual medical condition, you may need to see a specialist who is not affiliated with your primary hospital or medical group.

When you are referred, be sure to get a referral form from your primary care provider and take it to the specialist. The referral will state the number of visits and/or type of treatment to be provided by the specialist. Expired referrals must be renewed by the primary care provider if additional specialist care is required. Maternity care referrals are valid for the term of the pregnancy and the first 8 weeks thereafter.

Sometimes a specialist wants you to see another specialist. If so, you must check with your primary care provider, who will determine if the second referral is medically necessary.

Accessing Care

To receive benefits from the PacifiCare Health Management Option:

- You make an appointment with your primary care provider
- You pay the \$10 office visit copay at the time you receive health care services
- Your primary care provider will obtain preauthorization for your care as necessary
- The plan pays 100% for most covered services
- The plan handles all forms and paperwork.

For chemical dependency treatment or mental health care: You also may call King County's Making Life Easier Program at 1-888-874-7290. Staff will obtain preauthorization as necessary and refer you to a provider for treatment.

You may see any provider in an emergency. However, To receive most benefits, you must see or call your primary care provider first. Here are a few exceptions; you may receive these services from a *network provider* – without a referral from your primary care provider – and still receive benefits:

- Chiropractic care (maximum 33 visits a year without a referral; no maximum with a referral)
- Chemical dependency treatment (must be preauthorized by PacifiCare Behavioral Health)
- Mental health care (must be preauthorized by PacifiCare Behavioral Health)
- Urgent care
- Women's health care services (for example, maternity care, reproductive health services and gynecological care).

Call PacifiCare for information on network providers. Depending on the service, you may need to obtain preauthorization for your care; see the next page for details.

Second Opinions

On occasion, you may want a second opinion. To receive benefits from this plan, you must have a referral from your primary care provider.

Obtaining Preauthorization

You must obtain preauthorization if you don't see your primary care provider for these services:

- Chemical dependency treatment
- Mental health care
- Women's health care services (if the services involve hospitalization or surgery).

You do not need preauthorization for:

- Accidents (see page 40 for a definition)
- Emergencies (including detoxification).

However, you (or a family member or hospital staff member) are expected to call within 24 hours from the start of your care (48 hours for mental health care or chemical dependency treatment).

How to Call: To obtain preauthorization for care other than mental health care and chemical dependency treatment, have your physician call PacifiCare at 1-800-932-3004, 7:00 a.m. to 6:30 p.m. Pacific time, Monday - Friday.

To obtain preauthorization for mental health care and chemical dependency treatment, you or your physician must call PacifiCare Behavioral Health at 1-800-577-7244, 24 hours a day, 7 days a week. You also may call King County's Making Life Easier Program at 1-888-874-7290. Staff will obtain preauthorization for your care and refer you to a provider for treatment.

When calling PacifiCare Behavioral Health, be prepared to provide the following information:

- Your name
- Group number and member number (on your ID card)
- The reason for your call.

If You Don't Call: If your care is not preauthorized as described above, your care will not be covered.

If You Live Outside the Service Area

You are eligible for out-of-area benefits if you live outside PacifiCare's service area and more than 30 miles away from the nearest available primary care provider for at least 9 months out of each year. Call PacifiCare for information on service areas.

Here's how the out-of-area plan works:

- You pay a \$200 per person, \$600 per family, annual deductible (the deductible doesn't apply to prescription drugs)
- You make an appointment with a licensed provider (see page 42 for a definition)
- The plan pays 80% for most covered services; if you reach your \$1,000 per person (\$2,000 per family) out-of-pocket maximum, the plan pays 100% for most covered expenses for the rest of the year
- You must obtain preauthorization for certain procedures and services, as described in "Obtaining Preauthorization" starting on page 15.
- Depending on your provider, you may have to pay the bill in full and file a claim for reimbursement
- You are responsible for any charges that exceed UCR amounts (see page 44 for a definition).

Also see "If Your Family Member Lives Away From Home" page 34 for related information.

PacifiCare Health Management Option

If You Live Outside the Service Area (cont'd)

Mental Health Care and Chemical Dependency Treatment: Out-of-area participants do not need to see a PacifiCare Behavioral Health provider for mental health care or chemical dependency treatment (but you or your physician will need to obtain preauthorization for your care by calling PacifiCare Behavioral Health at 1-800-577-7244).

Prescription Drugs: You don't need to fill your prescriptions at a network pharmacy to receive benefits. Pay for the prescription in full and file a claim for a reimbursement. The plan pays 100% minus your copay (if any) per prescription.

Covered Expenses

The following section describes expenses covered by both the PacifiCare Choice Plan and PacifiCare Health Management Option. For information on the level of benefits you receive (for example, related coinsurance, copays, maximums and limitations), refer to “Medical Plan Summary” starting on page 3 for PacifiCare Choice Plan and page 11 for the PacifiCare Health Management Option. Also see “Expenses Not Covered” on page 31.

To be covered, services and supplies must be medically necessary. See definition on page 42. If you self-direct your care under the Choice Plan, certain services and supplies must be authorized before you receive care. See “Obtaining Preauthorization” starting on page 15 for details.

Alternative Care

Unless you self-direct your care under the Choice Plan, you must have a referral from your primary care provider to receive benefits for alternative care.

Covered services include professional services of a:

- Licensed accredited registered nurse practitioner
- Licensed acupuncturist
- Licensed naturopath
- Licensed physician’s assistant
- Licensed podiatrist
- Massage therapist, unless for recreational, sedative or palliative reasons; soft-tissue massage must be medically indicated
- Registered nurse.

These plans do not cover:

- Herbal preparations
- Nutritional supplements
- Teas.

Ambulance Services

Services of a licensed ambulance are covered to transport you to the nearest facility equipped to treat your condition, but only when other modes of travel would put you in danger.

Chemical Dependency Treatment

The plans cover treatment of chemical dependency by an approved alcoholism or drug treatment facility (see page 40 for a definition). This includes:

- Family therapy for the patient and covered family members
- Individual and group therapy
- Inpatient care (detoxification is covered as any other medical condition and charges for detoxification do not apply to the chemical dependency limit)
- Outpatient care
- Residential or day treatment.

You must obtain preauthorization from PacifiCare Behavioral Health or the county’s Making Life Easier Program as described in “Obtaining Preauthorization” (see page 9 for the Choice Plan and page 15 for the Health Management Option). You don’t need a referral from your primary care provider.

Chemical Dependency Treatment (cont'd)

The plans do not cover:

- Confinements or procedures that are not preauthorized by PacifiCare Behavioral Health (even if referred by your primary care provider)
- Treatment for addiction to or dependency on tobacco, nicotine or caffeine
- Volunteer support groups.

Chiropractic Care

The plans cover services of licensed chiropractors, limited to:

- Diagnostic laboratory services directly related to the spinal care treatment you are receiving
- Full spinal x-rays
- Noninvasive spinal manipulations.

You may see any network provider for care; you do not need a referral from your primary care provider. Call PacifiCare for a current list of network chiropractors.

Diabetes Care Training

The plan covers diabetic care training when prescribed by your primary care provider.

Durable Medical Equipment and Prosthetics

PacifiCare Choice Plan participants only: If you self-direct your care, you are responsible for obtaining preauthorization as described starting on page 9.

Durable medical equipment is covered if:

- Designed for prolonged use
- It has a specific therapeutic purpose in treating your illness or injury
- Prescribed by your physician, and
- Primarily and customarily used only for medical purposes.

Covered items include:

- Artificial limbs or eyes (including implant lenses prescribed by a network provider and required as a result of cataract surgery or to replace a missing portion of the eye)
- Casts, splints, crutches, trusses or braces
- Diabetic equipment such as blood glucose monitor, diabetic shoes and inserts and insulin pumps not covered under the prescription benefit (excluding batteries) when ordered by a provider to treat diabetes
- Initial external prosthesis and bra necessitated by breast surgery and replacement of these items when required by normal wear, a change in medical condition or additional surgery
- Ostomy supplies
- Oxygen and rental equipment for its administration
- Penile prosthesis when impotence is caused by a covered medical condition, a complication directly resulting from a covered surgery or an injury to the genitalia or spinal cord (and other accepted treatment has been unsuccessful)
- Rental or purchase (decided by PacifiCare) of durable medical equipment such as wheelchairs, hospital beds and respiratory equipment (combined rental fees may not exceed full purchase price)
- Wig or hairpiece to replace hair lost due to radiation therapy or chemotherapy for a covered condition.

Emergency Care

Emergency care is covered. Emergency care treats medical conditions that threaten loss of life or limb, or may cause serious harm to the patient's health if not treated immediately. Examples of conditions that might require emergency care include, but are not limited to:

- An apparent heart attack (chest pain, sweating, nausea)
- Bleeding that will not stop
- Convulsions
- Major burns
- Severe breathing problems
- Unconsciousness or confusion – especially after a head injury.

You do not need a referral from your primary care provider before you receive emergency care. See page 34 for instructions on what to do if you need emergency or urgent care.

Family Planning

Covered family planning expenses include:

- Intrauterine birth control devices (IUDs) and injectable birth control
- Tubal ligation
- Vasectomy
- Voluntary termination of pregnancy.

The plans do not cover:

- Infertility treatment, sterility or sexual dysfunction treatment or diagnostic testing
- Procedures to reverse voluntary sterilization.

Birth control drugs are covered under the prescription drug benefit described on page 25.

Growth Hormones

Growth hormones are not covered.

Hearing Aids

Hearing aids or ear molds are covered when medically necessary and referred by your PCP to provide functional improvement. They must be referred by and obtained from a plan provider.

Covered services include:

- Expenses relating to a basic hearing aid to provide functional improvement
- Replacement of a hearing aid that is lost, broken or stolen within 36 months of receipt
- Hearing aid repair and related services, including batteries.

Home Health Care

Home health care services are covered if:

- Care takes the place of a hospital stay
- Part of a home health care plan, and
- Provided and billed by a licensed Washington state home health care agency.

Services and prescription drugs provided and billed by a home infusion therapy company are also covered if the company is licensed by the state as a home health care agency.

Unless you self-direct your care under the Choice Plan, you must have a referral from your primary care provider to receive home health care benefits.

Home Health Care (cont'd)

PacifiCare Choice Plan participants only: If you self-direct your care, you are responsible for obtaining preauthorization as described starting on page 9.

Covered services include:

- Nursing care
- Occupational therapy
- Physical therapy
- Prescription drugs, if used by the patient during a period of covered home health agency care (prescription drugs included in a home health treatment plan will not require a copay)
- Respiratory therapy
- Restorative speech therapy
- Restorative therapy.

The following services are not covered:

- Custodial care, except by home health aides as ordered in the approved plan of treatment
- Housecleaning
- Services of any social worker
- Services or supplies not included in the written plan of treatment
- Services provided by a person who resides in your home or is a family member
- Travel costs or transportation services.

Hospice Care

Hospice care is a coordinated program of supportive care for a dying person by a team of professionals and volunteers. The team may include services by a physician; nurse; medical social worker; or physical, speech, occupational or respiratory therapist.

Unless you self-direct your care under the Choice Plan, you must have a referral from your primary care provider to receive hospice benefits.

PacifiCare Choice Plan participants only: If you self-direct your care, you are responsible for obtaining preauthorization as described starting on page 9.

Hospice care services are covered if:

- Care takes the place of a hospital stay
- Part of a hospice care treatment plan, and
- Provided and billed by an organization licensed as a hospice by Washington state.

Covered services include:

- Drugs and medications
- Emotional support services
- Home health services
- Homemaker services
- Inpatient hospice care
- Physician's services
- Respite care for family members who care for the patient.

The following services are not covered:

- Any services provided by members of the patient's family
- Bereavement or pastoral counseling
- Financial or legal counseling (examples are estate planning or the drafting of a will)

- Funeral arrangements
- Homemaker, caretaker or other services not solely related to the plan participant, such as:
 - House cleaning or upkeep
 - More than 5 days of respite care in any 3-month period of hospice care
 - Sitter or companion services for either the plan participant who is ill or for other family members
 - Transportation.

Hospital Care Inpatient

Unless you self-direct your care under the Choice Plan, you must have a referral from your primary care provider to receive inpatient benefits.

PacifiCare Choice Plan participants only: If you self-direct your care, you are responsible for obtaining preauthorization for inpatient and outpatient hospital care as described starting on page 9.

Covered inpatient hospital care includes:

- Hospital services, such as operating rooms, recovery rooms, isolation rooms, cast rooms; anesthesia and related supplies administered by hospital staff; drugs; splints, casts and dressings; blood, blood plasma and blood derivatives; artificial kidney treatment; oxygen and its administration; x-ray, radium and radioactive isotope therapy; x-ray and lab exams, electrocardiograms, physiotherapy and hydrotherapy
- Intensive care or coronary care units
- Newborn nursery care after covered childbirth, including circumcision, during the first 4 weeks of life
- Physician services
- Semiprivate room, meals, general nursing care (private room charges are covered only up to the hospital's semiprivate rate)
- Surgery and anesthesia administration.

Hospital Care Outpatient

Covered outpatient hospital care includes:

- Diagnostic and therapeutic nuclear medicine in a hospital setting
- Hospital outpatient chemotherapy only for the treatment of malignancies
- Outpatient surgery
- Surgery in an ambulatory surgery center in place of inpatient hospital care.

Infertility

The plans do not cover:

- Infertility treatment, sterility or sexual dysfunction treatment or diagnostic testing
- Procedures to reverse voluntary sterilization.

Injury to Teeth

Accidental injury to mouth and natural teeth is covered but limited to stabilization services received within 48 hours of the injury. Benefits for dental accidents cover a licensed dentist and a provider licensed as a denturist for services within the scope of that license that would have been covered if performed by a dentist.

Inpatient Care Alternatives

Your physician may develop a written treatment for care in an equally or more cost-effective setting than a hospital or skilled nursing facility. All hospital or skilled nursing facility benefit terms, maximums and limitations apply to the inpatient care alternatives.

Unless you self-direct your care under the Choice Plan, you must have a referral from your primary care provider to receive benefits for inpatient care alternatives.

PacifiCare Choice Plan participants only: If you self-direct your care, you are responsible for obtaining preauthorization as described starting on page 9.

Lab, X-ray and Other Diagnostic Testing

Unless you self-direct your care under the Choice Plan, you must have a referral from your primary care provider to receive lab, x-ray and other diagnostic testing benefits.

Covered services include:

- Lab or x-ray services, such as ultrasound, mammograms, nuclear medicine, allergy testing and administration of allergy serum (the serum itself is covered under “Physician and Other Medical Services” on page 24)
- Medically necessary hearing tests by the physician or a licensed audiologist
- Screening and diagnostic procedures during pregnancy as well as related genetic counseling (when medically necessary for prenatal diagnosis of congenital disorders)
- Services to diagnose or treat medical conditions of the eye by a provider licensed as an optometrist by Washington state; eyewear and routine vision exams and tests for vision sharpness are not covered under this benefit (see your Vision Plan booklet for details).

See “Preventive Care” on page 26 for more information on routine tests such as hearing tests.

Maternity Care

You may self-refer for women’s health care services including maternity care. Inpatient and outpatient surgery must be preauthorized.

Maternity care is covered if provided by a:

- Physician (a registered nurse whose specialty is midwifery is considered a physician for this purpose), or
- Registered nurse midwife.

Covered maternity care includes:

- Complications of pregnancy or delivery
- Hospitalization and delivery (see “Hospital Care” on page 21 for more information)
- Postpartum care
- Pregnancy care, including prenatal vitamins
- Related genetic counseling when medically necessary for prenatal diagnosis of congenital disorders of the unborn child
- Screening and diagnostic procedures during pregnancy.

The plans do not cover:

- Home pregnancy tests
- Maternity services for dependent children
- Planned deliveries in other settings, such as your home.

Group health plans and health insurance issuers offering group insurance coverage generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Mental Health Care

Inpatient and outpatient mental health care is covered. The mental health care benefit is provided through an arrangement between PacifiCare of Washington and PacifiCare Behavioral Health. To be covered, mental health care must be performed by a hospital, physicians (such as psychiatrists, psychologists and registered nurses), residential treatment facilities, providers licensed or certified as required by the state to provide mental health counseling, community mental health agencies licensed by the state and state mental hospitals.

Covered services include the following, when medically necessary:

- Individual and group psychotherapy
- Laboratory services related to the covered provider's approved treatment plan
- Marriage and family therapy
- Physical exams and intake history
- Psychological testing.

You must obtain preauthorization from PacifiCare Behavioral Health or the county's Making Life Easier Program as described in "Obtaining Preauthorization" (see page 9 for the Choice Plan and page 15 for the Health Management Option).

You do not need a referral from your primary care provider.

The plans do not cover:

- Certain nonorganic therapies: bioenergetic therapy, confrontation therapy, crystal healing therapy, educational remediation, guided imagery, marathon therapy, primal therapy, rolfing, sensitivity training, training analysis, transcendental meditation, Z therapy or milieu therapy
- Certain organic therapies: aversion therapy (includes electric shock for behavioral modification), carbon dioxide therapy, environmental ecological treatment or remedies, herbal therapies, hemodialysis for schizophrenia, vitamin or orthomolecular therapy, L-tryptophan and vitamins, narcotherapy with LSD or sedative action electrostimulation therapy
- Conditions of or related to substance use or abuse are covered under chemical dependency treatment
- Long-term, insight-oriented psychotherapies designed to regress the plan participant emotionally or behaviorally
- Mental retardation
- Pathological gambling
- Personal enhancement or wellness development and related programs not considered medically necessary
- Private rooms and private duty nursing
- Spiritual counseling, dance, poetry, music or art therapy
- Surgery as a treatment for a mental disorder.

Mental Health Care (cont'd)

Without a psychiatric diagnosis of a mental condition, the plans also don't cover:

- Bereavement or catastrophic illness counseling
- Biofeedback
- Counseling related to adoption, custody, family planning or pregnancy
- Sex therapy and sexual addiction therapy.

Neurodevelopmental Therapy

The plans cover neurodevelopmental therapy for covered family members age 6 and younger.

Covered services include:

- Hospital care
- Maintenance of the patient when his or her condition would significantly worsen without such services
- Occupational, speech and physical therapy (if ordered and periodically reviewed by a physician)
- Physicians' services
- Services to restore and improve function.

Unless you self-direct your care under the Choice Plan, you must have a referral from your primary care provider to receive neurodevelopmental therapy benefits.

PacifiCare Choice Plan participants only: If you self-direct your care for inpatient neurodevelopmental therapy, you are responsible for obtaining preauthorization as described starting on page 9.

Newborn Care

The plan covers newborns under the mother's coverage for the first 3 weeks, as required by Washington State law. To continue the newborn's coverage after 3 weeks, the newborn must be eligible and enrolled by the deadline described. See your "Important Facts" booklet for details.

Physician and Other Medical and Surgical Services

The following services are covered by these plans:

- Immunization agents or biological sera, such as allergy serum
- Medical care in the physician's or alternative provider's office
- Nutritional counseling by a registered nutritionist or dietitian when medically necessary for disease management
- Physician services for surgery, anesthesia, inpatient and emergency room visits
- Second opinions obtained prior to a treatment (the provider giving the second opinion must be qualified, either through experience or specialist training).

PacifiCare also has the right to ask for a second medical opinion to confirm the medical necessity of a proposed surgery or treatment plan.

PKU Formula

The plans cover the medical dietary formula that treats Phenylketonuria (PKU). You may order up to 5 cases in any calendar month.

Prescription Drugs

These plans offer you choices for obtaining covered prescription drugs. You may use the mail order program or network pharmacies. You may order up to a 90-day supply per prescription or refill under the mail order program, or up to a 30-day supply from a network pharmacy.

Prescriptions dispensed by pharmacies other than the mail order pharmacy or network pharmacies are covered only in an *emergency*, as defined on page 41, or *for out-of-area plan participants*.

PacifiCare Choice Plan participants only: If you self-direct your care, you must obtain preauthorization for certain prescription drugs before the plans pay benefits; see “Obtaining Preauthorization” starting on page 9 for more information.

Covered Prescription Drugs: The following prescription drugs are covered under the plans:

- Compounded medication (other than those listed in “Drugs Not Covered” on page 26) made up of at least 1 prescription drug
- Glucagon emergency kits
- Needles and syringes equal to the supply of covered self-administered injectable drugs dispensed; glucose testing strips, injection devices (when medically necessary) and lancets are also covered, up to a supply equaling the supply of covered insulin dispensed (you pay a prescription drug copay for these supplies in addition to the copay for the related drug)
- Oral and injectable birth control prescription drugs, devices and supplies that require a physician’s prescription by law
- Prescription drugs (other than those listed in “Drugs Not Covered” on page 26) that can be dispensed only by written prescription of a physician or someone else authorized to prescribe that drug under applicable state law; insulin is also covered.

How to Use the Mail Order Pharmacy: The first time you use the mail order pharmacy, fill out the patient information questionnaire on your prescription drug order form. *This questionnaire only needs to be completed once.* The information is maintained by the pharmacy and will assist the pharmacist in cross-checking future medicines for drug allergies.

Each time you order, send the prescription drug order form with your payment directly to the mail order pharmacy’s address on the form. You may include your physician’s written prescription with your order form and payment, or you may have your physician telephone the prescription directly to the mail order pharmacy. The pharmacy’s toll-free number is shown on the prescription drug order form.

All prescriptions are processed promptly and are usually returned to you in 10 to 14 days. If you don’t receive your medicine within 14 days or have questions about your medicine, call the mail order pharmacy at 1-800-562-6223.

How to Use the Network Pharmacies: An extensive network of pharmacies has agreed to dispense covered prescription drugs to plan participants at a discounted cost and not to bill plan participants for any amounts over the copay. You may go to any network pharmacy (a referral from your primary care provider is not necessary).

Here’s how it works:

- Choose a network pharmacy (call PacifiCare to find a pharmacy near you)
- Show your ID card to the network pharmacist each time you want a prescription filled or refilled (PacifiCare will issue an ID card for each participant; parents buying covered drugs for their children should show the ID card of the child who will be taking the medicine)
- Pay the copay for each covered prescription or refill
- There are no claim forms to submit; the network pharmacy will bill the plan directly.

Prescription Drugs (cont'd)

If you do not show your ID card, and the network pharmacy cannot reach PacifiCare to confirm you are covered by these plans, no benefits will be provided.

The only exceptions are for:

- Emergencies, as defined on page 41
- Out-of-area plan participants
- Plan participants to whom an ID card has not yet been issued.

In these situations, you will need to pay the pharmacy in full and submit the claim to PacifiCare.

Drugs Not Covered: The following prescription drugs and items are not covered:

- Appetite suppressants
- Birth control devices, supplies or preparations that do not require a physician's prescription by law, even if you have a prescription; birth control implants, such as Norplant, are not covered (this exclusion applies regardless of intended use)
- Drugs labeled Caution – limited by federal law to investigational use, or experimental drugs (see page 41 for more information)
- Drugs prescribed by a provider not authorized by the state to prescribe the drugs or by a type of provider not covered under these plans; drugs dispensed by a provider other than a network or mail order pharmacy are not covered (however, benefits may be available under other benefits described in this booklet, for example, hospital inpatient care)
- Growth hormone, regardless of intended use
- Lifestyle drugs, including but not limited to anti-obesity drugs, anti-aging drugs and prescription drugs used to treat sexual dysfunction
- Nicotine-containing preparations in any form unless you're currently enrolled in the Stop Smoking Program and authorized for nicotine patches
- Nonprescription drugs, other than insulin or prescription drugs that are equivalent to nonprescription drugs
- Retin-A, when used for cosmetic purposes
- Therapeutic devices and appliances, support garments and other nonmedical supplies
- Vitamins (except for prenatal vitamins).

Preventive Care

The following preventive care is covered:

- Immunizations, including annual flu shots
- Routine tests, such as physicals, Pap tests and hearing tests.

Mammograms are covered by these plans but not under the preventive care benefit; see "Lab, X-ray and Other Diagnostic Testing" on page 22. Home cholesterol tests are not covered.

Preventive care benefits are payable according to the following schedule:

Birth to 1 year	Routine newborn care, plus 5 visits
1 - 5 years	6 visits/year
6 and older	1 visit/year

You don't need a referral from your primary care provider before you see a network provider for women's health care services (such as maternity care, reproductive health services and gynecological care). However, depending on the service (for example, if you need surgery), you may need to obtain preauthorization; see page 9 or 15 for details.

The following programs are also covered if arranged or provided by the PacifiCare Wellness Company. If you have questions about any of these programs, call the phone numbers listed in each section. You do not need a referral from your primary care provider to take advantage of these programs.

Stop Smoking Program: The 2-step Stop Smoking Program allows you to quit smoking at your own pace. Here's how it works:

- Call 1-800-513-5131 to register.
- A kit containing a video, a cassette, and booklets will be mailed to your home. The kit will help you prepare for and set a date to stop smoking. It also helps you learn how to resist the smoking urge.
- Within a week after you receive your kit, a trained smoking cessation specialist will call you to go over the program. The specialist is an ex-smoker and can focus on your needs to help in the quitting process.
- The specialist will continue to call you to provide the support you need. You and the specialist agree on when and where the calls will be made to make sure the program works best for you.
- If your PCP prescribes nicotine replacement therapy, you'll find out how to obtain it when you enroll.
- This benefit does not cover inpatient care or support group fees.

Healthy Pregnancy Program: This program is designed to help women learn how to care for themselves during their pregnancies and how to care for their new babies. The program is designed to complement prenatal medical care. To enroll, call PacifiCare toll free at 1-800-932-3004.

After you enroll, you will receive 3 home mailings. In the first mailing, you'll receive a book, videotape and brochures describing how to take care of yourself during pregnancy. The second mailing provides a videotape and brochures on infant care. The last mailing includes a book that discusses infant safety, clothing and general infant care.

Exercise Program: To encourage you to make a habit of regular exercise, PacifiCare offers preferred pricing for you and your covered family members at local area health clubs. Preferred pricing may vary from club to club. Call PacifiCare at 1-800-932-3004 to find out about participating health clubs and costs.

Radiation Therapy, Chemotherapy and Respiratory Therapy

Inpatient and outpatient services are covered for medically necessary radiation, chemotherapy and respiratory therapy when prescribed by your primary care provider.

Reconstructive Services

The following reconstructive services are covered when preauthorized by PacifiCare:

- Benefits available under the plans for covered individuals who are receiving benefits for a mastectomy and elect breast reconstruction in connection with the mastectomy in a manner determined in consultation with the patient and attending physician include (subject to the same annual deductible and coinsurance provisions as other plan medical and surgical benefits):
 - Reconstruction of the breast on which the mastectomy was performed
 - Surgery and reconstruction of the other breast to produce a symmetrical appearance
 - Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas
- Reduction mammoplasty when established medical criteria are met
- Removal of breast implants
- To correct a congenital anomaly or disease of a child as determined by the plan provider
- Treatment for an injury within 6 months after an accident giving rise to such injury, or as soon as medically feasible.

Rehabilitative Services

Unless you self-direct your care under the Choice Plan, you must have a referral from your primary care provider to receive benefits for inpatient or outpatient rehabilitative care.

PacifiCare Choice Plan participants only: If you self-direct your care, you are responsible for obtaining preauthorization for inpatient rehabilitative care as described starting on page 9.

Inpatient: Inpatient rehabilitative care is covered if:

- It is medically necessary to restore or improve normal body functions lost or impaired due to illness or injury
- The services are ordered by a physician
- The services could not be done in a less intensive setting, and
- You receive the care in a hospital or Medicare-certified inpatient rehabilitative facility.

Covered services include physical, speech and occupational therapy and other services normally a part of inpatient rehabilitative care.

Outpatient: Outpatient rehabilitative care is covered if:

- It is medically necessary to restore or improve normal body functions lost or impaired due to illness or injury
- The care is received from a provider licensed, registered or certified as required by the state to provide such services, and
- The services are ordered by a physician.

Covered services include physical, speech and occupational therapy.

The outpatient rehabilitative care benefit does not cover:

- Care to halt or slow further physical deterioration
- Disorders and delays in the development of motor, speech, language or cognitive skills, such as dyslexia, stuttering and attention deficit disorders (benefits may be available under neurodevelopmental therapy)
- Self-help training (such as Outward Bound or recreational therapy)
- Social, vocational and cultural rehabilitation.

Skilled Nursing Facility

Skilled nursing facility services are covered if:

- Provided and billed by a licensed Washington state skilled nursing facility, and
- The care takes the place of a hospital stay.

Prescription drugs are covered when provided by the skilled nursing facility and used by the patient during a period of covered skilled nursing facility care.

Unless you self-direct your care under the Choice Plan, you must have a referral from your primary care provider to receive skilled nursing facility benefits.

PacifiCare Choice plan participants only: If you self-direct your care, you are responsible for obtaining preauthorization as described starting on page 9.

The following services are not covered:

- Custodial care furnished in a skilled nursing facility or services not usually provided by a skilled nursing facility
- Services or supplies not included in the written plan of treatment
- Services provided by a person who resides in your home or is a family member
- Travel costs.

Skilled nursing facility confinement for developmental disability, mental condition or primarily domiciliary, convalescent or custodial care is not covered.

TMJ

The temporomandibular joint is the joint that connects the mandible, or jawbone, to the temporal bone of the skull. Temporomandibular joint disorders include those disorders that have one or more of the following characteristics: pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint or an abnormal range of motion or limited range of motion of the temporomandibular joint.

This benefit provides services and supplies that are:

- Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty speaking or difficulty in chewing or swallowing food
- Not experimental
- Not primarily for cosmetic purposes
- Provided or referred by the member's PCP
- Reasonable and appropriate for treatment of a disorder of the temporomandibular joint, and
- Recognized as effective, according to the professional standards of good medical practice.

The plan will cover medical services only. This benefit does not cover dental services.

Transplants

The plans do not cover organ, bone marrow or stem cell transplant (except skin grafts) expenses incurred during the first 12 consecutive months after your coverage begins. If you transfer coverage from another PacifiCare plan, this waiting period is reduced by the time you were continuously covered under the prior PacifiCare plan.

You must have a referral from your primary care provider to receive transplant benefits.

Transplants (cont'd)

PacifiCare Choice Plan participants only: The plan does not cover transplant services that are self-directed.

The following transplants are covered:

- Cornea
- Double lung, for cystic fibrosis only
- Heart
- Heart-lung
- Kidney
- Liver
- Pancreas with kidney
- Single lung.

Skin grafts may be covered under other plan benefits. Bone marrow, hematopoietic stem cells or both from a person other than the covered patient are covered for these diagnoses only:

- Acute lymphocytic or acute nonlymphocytic leukemia
- Advanced or severe myelodysplasia
- Aplastic or chronic myelogenous leukemia
- Hodgkin's lymphoma, limited to stage 3 or 4
- Homozygous beta-thalassemia
- Infantile malignant osteopetrosis
- Neuroblastoma, medulloblastoma or primitive neuroectodermal tumors (stage 3 and 4 in children over age 1)
- Non-Hodgkin's lymphoma, limited to stage 3 or 4 of intermediate or high grade
- Severe combined immunodeficiency (not HIV or AIDS)
- Wiskott-Aldrich syndrome.

The covered patient's own bone marrow, hematopoietic stem cells or both are covered for these diagnoses only:

- Acute lymphocytic or acute nonlymphocytic leukemia
- Breast cancer, high risk stage 2 or 3 only
- Germ cell
- Hodgkin's lymphoma, limited to stage 3 or 4
- Neuroblastoma, medulloblastoma or primitive neuroectodermal tumors (limited to stage 3 or 4)
- Non-Hodgkin's lymphoma, limited to stage 3 or 4 of intermediate or high grade.

The following services and supplies are covered for the recipient:

- Chemotherapy or radiation therapy to prepare for a bone marrow or stem cell transplant
- Covered medical care starting 3 days before the transplant date and follow-up care including anti-rejection drugs
- Donor costs, including removal of an organ, bone marrow or stem cells from a live donor and 10 consecutive days of care; the donor need not be a plan participant, and benefits will be coordinated with the donor's group plan as described in "Coordination of Benefits" on page 37
- Harvesting an organ from a cadaver and transporting the organ
- Tissue typing and matching of the recipient's parents, children, brothers or sisters.

These plans do not cover:

- Care (related to the transplant) received during the 12-month transplant waiting period; see page 29.
- Donor costs when the donor is a plan participant but the recipient is not
- Organ, bone marrow and stem cell transplants (or transplants for conditions) not listed in this section
- Services for which government funding is available, other than Medicare, Medicaid or CHAMPUS (except as otherwise required by law)
- Storage costs for any organ or bone marrow
- Tissue typing and matching for anyone other than the family members listed in this section
- Transplants of mechanical or nonhuman organs
- Transplants that are experimental or investigational
- Transportation of any family members for typing and matching.

Urgent Care

These plans cover urgent care, which is treatment for conditions that are not life threatening but may need immediate attention. Examples of urgent conditions include:

- Ear infections
- High fevers
- Minor burns.

Urgent care is covered the same as other care. Generally, urgent care involves an office visit and is paid at the level shown on page 5 for the Choice Plan and page 12 for the Health Management Option.

See page 34 for instructions on what to do if you need urgent care.

Expenses Not Covered

In addition to the limitations and exclusions described in other sections of this booklet, the plans do not cover:

- Acupressurist or homeopath procedures or those supplied by a Christian Science practitioner/sanitarium or rabbi
- Biofeedback
- Charges in excess of UCR amounts (see page 44 for a definition)
- Child's pregnancy or termination of pregnancy
- Claims not made to PacifiCare within 12 months of the date of service; if you cannot send in the claim on time due to circumstances beyond your control, PacifiCare will consider the claim for payment if you write and explain the circumstances
- Conditions for which the Veterans' Administration, federal, state, county or municipal government or any of the armed forces is responsible or provides treatment, except as required by law
- Conditions resulting from service in the armed forces, declared or undeclared war or voluntary participation in a riot, insurrection or act of terrorism
- Convalescent or custodial care, no matter where it's given, or any part of a hospital stay that is primarily convalescent or custodial (this exclusion does not apply to home health and hospice care if a part of an approved treatment plan)

Expenses Not Covered (cont'd)

- Cosmetic, plastic or reconstructive procedures furnished primarily to improve or change appearance; the only exceptions are:
 - Reconstructive breast surgery following mastectomy needed due to illness or injury; reduction of the healthy breast to make it the same size as the diseased breast; reduction mammoplasty when established medical criteria are met
 - Removal of breast implants
 - Treatment for an injury within 6 months after the accident causing the injury (or as soon as medically feasible)
 - Treatment of a birth defect in a child continuously covered by the plans from birth or from date of placement for legal adoption
- Examples of cosmetic expenses that are not covered include:
 - Breast enlargement, reduction or uplift except as stated above
 - Reshaping of the nose (rhinoplasty)
 - Revision of scars or keloids
 - Surgery for sagging skin of the eyelids, face, neck, abdomen, hips or extremities
- Court-ordered programs, services or supplies, or those related to deferred prosecution, deferred or suspended sentencing or driving rights (unless considered medically necessary by PacifiCare)
- Dental care, except treatment for accidental injury to the mouth and natural teeth received within 48 hours of the injury; benefits for dental accidents cover a provider licensed as a denturist for services within the scope of that license that would have been covered if performed by a dentist; hospital care to extract teeth or for other dental care also is not covered — unless adequate care cannot be provided outside the hospital and an underlying medical condition requires hospitalization (preauthorization is required)
- Educational or self-help training except as covered under Diabetes Care Training (see page 18) and Healthy Pregnancy Program (see page 27)
- Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance
- Enteral therapy or nutritional supplements
- Evaluation and treatment of learning disabilities, except as provided for neurodevelopmental therapies
- Exams, tests or shots required for work, insurance, school, marriage, adoption, immigration, camp, volunteering, travel, license, certification, registration, sports or recreational activities
- Experimental or investigational procedures as described on page 41
- Foot care, such as:
 - Fallen arches or other symptomatic complaints unless associated with a disease affecting lower limbs, such as diabetes
 - Prosthetics and appliances or orthotics connected with or inserted in shoes and impression casting for them, unless associated with diabetes
 - Trimming of nails, corns or calluses, unless associated with diabetes
- Growth hormones
- Habilitative therapy for hyperkinetic syndromes of childhood (such as dyslexia) or specific delays in cognitive, motor, speech and language development (such as attention deficit disorders), except as covered under “Neurodevelopmental Therapy” on page 24

- Illness or injury from or during work — even if medical care is not covered by workers compensation or other laws or by the county’s insurance (this exclusion does not apply if workers compensation finds the injury or illness is not related to your work)
- Jaw augmentation or reduction (orthognathic surgery), except when medically necessary to treat a participant continuously covered by these plans from birth or from the date of placement for legal adoption
- Prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy or hyporgasmy
- Prescription or nonprescription drugs and medicines for outpatient use, or take home drugs from inpatient stays other than those covered under specific benefits; the plans do not cover food items (except covered PKU formula; see page 24), over-the-counter items or prescription drugs that are not preauthorized (if preauthorization is required)
- Procedures, services, supplies, and medications until they are reviewed for safety, efficacy, and cost effectiveness and approved by PacifiCare
- Procedures that are:
 - By a provider related to you by blood, marriage, adoption or legal dependency
 - Covered under motor vehicle medical or “no fault” coverage, personal injury protection or similar insurance (this exclusion does not apply to uninsured motorist or underinsured motorist insurance coverage)
 - Furnished by a provider not licensed, registered or certified to perform them as required by the state where the provider is practicing
 - Not covered by the provider’s malpractice insurance
 - Not medically necessary as determined by PacifiCare
 - Obtained without a referral if required from your primary care provider
 - Outside the scope of the provider’s license, registration or certification
 - Received while you are not covered by the plan
- Reproductive and sexual disorders or defects (whether or not the consequence of illness, disease or injury) such as:
 - Artificial insemination or in vitro fertilization
 - Fertility or sterility studies
 - Frigidity
 - Impotence (except as specifically provided under “Durable Medical Equipment and Prosthetics” on page 18)
 - Procedures to restore or enhance fertility
 - Reversal of sterilization
 - Sex change procedures
- Services that are not medically necessary for the diagnosis, treatment, or prevention of injury or illness, or to improve the functioning of a malformed body member, even though such services are not specifically listed as exclusions
- Services to treat obesity such as weight control programs, surgery or wiring of the jaw
- Vision care, for example:
 - Orthoptics
 - Radial keratotomy or any surgery to change the refractive character of the cornea
 - Refractions, frames, lenses, and contact lenses
 - Vision analysis, therapy or training relating to muscular imbalance of the eye.

What Happens If

If You Need Emergency Care

Emergency care treats medical conditions that threaten loss of life or limb, or may cause serious harm to the patient's health if not treated immediately. If you need emergency care, follow these steps:

- Dial 911 or go to the nearest hospital emergency room immediately.
- When you arrive, show your medical plan membership card.
- If you're admitted, call PacifiCare at 1-800-932-3004 within 24 hours; otherwise, you may be responsible for all costs incurred before you call. If you're unable to call, have a friend, relative or hospital staff person call for you. The telephone numbers are also printed on the back of your ID card.

If you have an emergency as determined by the plans, benefits are paid as described on page 3 in the Choice Plan or page 11 in the Health Management Option. Follow-up care will be paid as any other care.

If You Need Urgent Care

Sometimes you may need to see a physician for conditions that are not life threatening but need immediate medical attention.

- For urgent care during office hours, call your physician's office for assistance.
- After office hours, call your physician's office and leave your name and number; the physician on-call will call you back. Depending on your situation, the physician may provide instructions over the phone, ask you to come into his or her office or advise you to go the nearest emergency room.

PacifiCare Choice Plan participant only: Plan benefits for urgent care will depend on the provider you see; refer to page 5 for details.

PacifiCare Health Management participants only: To receive benefits, your primary care provider must provide or coordinate your urgent care.

If You Need Care While Traveling

If you need care while traveling, contact your physician for guidance.

If you are in the PacifiCare Choice Plan: You have the same coverage when you travel as you do when you're home. If your primary care provider doesn't provide or coordinate your care, you receive self-directed benefits.

If you are in the PacifiCare Health Management Option: Emergency care is covered while you travel. All other care (including urgent care) is generally not covered, unless your primary care provider authorizes your care.

If your Family Member Lives Away From Home

Family members who live outside the PacifiCare service area either temporarily or permanently may be eligible for out-of-area benefits. See "If you Live Outside the Service Area" on page 10. For details. If your family members don't qualify for out-of-area benefits, they receive benefits as if they were traveling; see previous section for details.

Filing a Claim

On occasion, you'll need to submit claims for services rendered by non-network providers. Claim forms are available from PacifiCare (there is a special claim form for prescription drugs).

If you're covered by Medicare, and Medicare is your primary coverage, you must submit the Medicare Explanation of Benefits form in addition to PacifiCare's claim form and itemized bill.

When submitting any claim, attach PacifiCare's claim form to the itemized bill, which *must* contain:

- Patient's name
- Provider's tax ID number
- Diagnosis or ICD-9 code
- Date of service
- Itemized charges from the provider for the services received
- If treatment is the result of an accident, the date, time, location and brief description of the accident
- Group number (shown on your ID card)
- Employee's name and Social Security number, if the patient is a family member.

A separate claim form is necessary for each patient. When filling out the form, be sure to complete all required information, sign the form and attach the itemized bill.

For efficient payment, submit all claims within 30 days after the service is provided. PacifiCare will not pay a bill submitted more than 12 months after the date of service. If you can't meet the 12-month deadline because of circumstances beyond your control, the claim will be considered for payment when accompanied by a written explanation of the circumstances.

If you receive services from a non-network provider and the claim form indicates full payment has been made, payment for covered services will be made directly to you.

Medical Claims

Send your claims to:
PacifiCare of Washington
PO Box 3005
Hillsboro OR 97123-3005

When there is no indication the bill has been fully paid, payment will be made to the provider.

Mental Health and Chemical Dependency Claims

To submit claims for benefits offered through PacifiCare Behavioral Health, send your claim to:

PacifiCare Behavioral Health
23046 Avenida de la Carlota, Suite 700
Laguna Hills CA 92653

Prescription Drug Claims

Mail prescription drug claims to:

Prescription Solutions
PO Box 6037
Cypress CA 90630-0037

Please include:

- Copy of your ID card
- Explanation for not using ID card at the time of purchase
- Pharmacy receipt, which shows the cost, drug's name, patient's name and date the drug was dispensed
- National Drug Code (NDC) number for each drug (found on the prescription label); the claim cannot be processed without this number.

Appealing a Claim

When you become eligible for benefit payments, you must follow certain steps for filing a claim. If your claim is denied in whole or in part, you will be notified in writing of the reason for the denial within 90 days from the date you filed your claim. The notice will include information required if you want to appeal.

You may appeal a denied claim within 12 months of the date you receive the denial notice. This procedure is the only means available to change a benefit decision. To appeal, write to the plan and state the reasons you believe your claim should have been paid.

Include any additional documentation to support your claim. You also may submit questions or comments you think are appropriate, and you may review relevant documents.

Normally, you will receive a written decision on your appeal within 60 days of the date the plan receives your request. If special circumstances require a delay, you will be notified of the extension during the 60 days following receipt of your request.

Send your appeal to:

Appeals & Grievance Representative
PacifiCare of Washington
PO Box 3007
Hillsboro OR 97123-9964

Release of Medical Information

When you join one of the PacifiCare plans, you authorize PacifiCare to receive and release information concerning your claims when necessary. In administering the plans, PacifiCare may need to contact your provider or other person, organization or insurance company to obtain or release information such as medical records.

Physical Exam

PacifiCare, at their own expense, may have a physician examine the covered patient when an injury or sickness is the basis of a claim. PacifiCare may examine the patient as often as necessary while the claim is pending.

Qualified Medical Child Support Order (QMCSO)

The plan may provide medical coverage to certain children of yours if directed by certain court or administrative orders. Refer to your “Important Facts” booklet for information.

Coordination of Benefits

This section applies to you if you or an eligible family member is covered by both this plan and a plan not sponsored by the county (and you expect reimbursement from both plans). If you and your eligible family member are covered under a county-sponsored plan both as an employee and as a family member, different rules will apply. Contact Benefits and Well-Being for details.

If you or your family members have additional health care coverage, benefits from the other plan(s) may be considered before benefits are paid under this plan. Additional coverage includes another employer’s group benefit plan or other group arrangement – whether insured or self-funded.

The plan that must pay benefits first is considered primary and will pay without regard to benefits payable under other plans. When another plan is primary, this plan will coordinate benefits so you receive maximum coverage. In no case will you receive more than 100% of the covered expense.

If you or your family members are covered under another plan, be sure to keep a copy of your itemized bill and send the bill and Explanation of Benefits to this plan.

If the other plan does not have a coordination of benefits provision, that plan will pay first. If it does, the following rules determine payment:

- The plan covering an individual as an employee will pay first.
- The plan of the parent whose birthday is first in the calendar year pays for covered children first unless the parents are divorced or legally separated. (If the other plan does not have this rule, the other plan’s provisions will apply.)
- If the parents are divorced or legally separated, these rules apply:
 - If the parent with custody (or primary residential placement) has not remarried, the plan of that parent pays before the plan of the parent without custody
 - If the parent with custody has remarried, the plan that covers the child is determined in this order: plan of the parent with custody, plan of the spouse of the parent with custody, plan of the parent without custody, plan of the spouse of the parent without custody
 - If the court decree establishes financial responsibility for the child’s health care, the plan of the parent with that responsibility will pay first.

If these provisions don’t apply, the plan that has covered the employee longer pays first.

Nevertheless, if either parent is retired, laid off or a family member of a retired or laid-off person, the plan of the person actively employed will pay first (unless the other plan doesn’t have a provision regarding retired or laid-off employees).

The plans have the right to obtain and release data as needed to administer these coordination procedures. For example, if the plans paid too much under the coordination of benefits provision, the plans have the right to recover the overpayment from you or your provider.

Coordination of Benefits with Medicare

If you continue to work for the county after age 65 you may:

- Continue your medical coverage under this plan and integrate the county plan with Medicare (the county plan would be primary or pay benefits first).
- Discontinue this medical coverage and enroll in Medicare. If you choose this option, your covered family members are eligible for continuation of coverage under COBRA for up to 36 months. See “Continuation of Coverage (COBRA)” in your “Important Facts” booklet for information.

Federal rules govern coordination of benefits with Medicare. In most cases, Medicare is secondary to coverage as an active employee or family member of an active employee. Medicare is primary in most other circumstances.

If you have any questions about how your coverage coordinates with Medicare, contact Benefits and Well-Being.

When Coverage Ends

Refer to your “Important Facts” booklet for information on when coverage ends.

Certificate of Coverage

When your coverage under one of these plans ends, you will automatically receive a certificate of health plan coverage. This is an important document and should be kept in a safe place. You may take this certificate to another health plan to receive credit against a preexisting condition limit for the time you were covered under one of these plans. You will need to do this only if the other health plan has a preexisting condition limit.

Continuation of Coverage (COBRA)

Continued coverage may be available to you and your covered family members under COBRA if coverage ends because of a qualifying event. Refer to your “Important Facts” booklet for more information.

Converting Your Coverage

If you're no longer eligible for the medical coverage described in this booklet, you may transfer your coverage to an insured conversion plan. The plan you convert to will differ from the plan benefits described in this booklet. You must pay premiums, which may be higher than amounts you currently pay, if any, for these benefits.

You will not be able to convert to the individual policy if you:

- Are eligible for any other medical coverage under any other group plan (including Medicare)
- Have reached the lifetime maximum benefit.

To apply for a conversion plan, you must complete and return an application form to PacifiCare within 31 days after this medical coverage terminates. Evidence of insurability will not be required.

Contact PacifiCare at 1-800-932-3004 for conversion forms and more information. You will not receive this information unless you request it.

Extension of Coverage

If these plans are canceled, PacifiCare will continue to cover any participants who are hospital inpatients on the date the plans are canceled. Coverage will end on the date of discharge or when you reach the plan maximums – whichever comes first.

Assignment of Benefits

Plan benefits are available to you and your covered family members only. Refer to your "Important Facts" booklet for information.

Third Party Claims

If you receive benefits for any condition or injury for which a third party is liable, the plan may have the right to recover the money paid for benefits. Refer to your "Important Facts" booklet for information.

Recovery of Overpayments

The plan has the right to recover amounts paid that exceed the amount for which they are liable. Refer to your "Important Facts" booklet for information.

Payment of Medical Benefits

The medical benefits offered by these plans are funded by PacifiCare (these are not “self-funded” plans). This means PacifiCare is financially responsible for claim payments and other costs of the program.

Termination and Amendment of the Plans

Refer to your “Important Facts” booklet for information on termination and amendment of the plans.

Definitions

To help you better understand your medical benefits, here’s a list of important definitions.

Accident. A sudden and unforeseen event that occurs at a specific time and place and results in bodily hurt to the plan participant. It is independent of illness other than infection of a cut or wound received in an accident.

Annual Deductible. The amount plan participants pay each plan year before a plan pays benefits. There is no annual deductible for these plans unless you are eligible for out-of-area benefits.

Annual Out-of-Pocket Maximum. The most a plan participant pays toward coinsurance and most copays each plan year.

Approved Alcoholism or Drug Treatment Facility. Any hospital or public or private treatment facility (or unit in the hospital or facility) that provides services for treating chemical dependency and operates under the direction and control of or contracts with the Department of Social and Health Services. (The approved facility will have ADESTA certification.) When required by the plans, the facility also must be approved by PacifiCare Behavioral Health.

Brand-Name Drugs. Trademark drugs patented for a limited period by a single pharmaceutical company.

Chemical Dependency. A psychological and/or physical dependence on alcohol or a state-controlled substance. The pattern of use must be so frequent or intense that the user loses self-control over the amount and circumstances of use, develops symptoms of tolerance and, if use is reduced or discontinued, shows symptoms of physical and/or psychological withdrawal. The result is that health is substantially impaired or endangered, or social or economic function is substantially disrupted.

Coinsurance. The amount you and your plan share toward covered expenses. For example, if the plan pays 60% coinsurance for the care you receive, your coinsurance is 40%.

Copay. The fixed amount you pay at the time you receive the covered service. Not all covered services require copays; see “Medical Plan Summary” starting on pages 3 and 11 for details.

Custodial or Convalescent Care. Care primarily to assist the patient in activities of daily living, including inpatient care mainly to support self-care and provide room and board. Examples are helping the participant to walk, get in and out of bed, bathe, dress, eat or prepare special diets or take medication that is normally self-administered.

Dental Care. Care of or related to the mouth, gums, teeth, mouth tissues, upper or lower jaw bones or attached muscle, upper or lower jaw augmentation or reduction procedures, orthodontic appliances, dentures and any care generally recognized as dental. This also includes related supplies, drugs and devices.

Durable Medical Equipment. Mechanical equipment that can stand repeated use and multiple users, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury and is prescribed by a physician.

Emergency. A medical condition that threatens loss of life or limb, or may cause serious harm to the patient's health if not treated immediately.

Experimental or Investigational. Procedures that are not medically necessary, have not been proven effective for your condition or are not generally accepted as a standard of good medical practice. PacifiCare's medical professionals consider a procedure experimental or investigational if it meets any conditions below on the date the procedure is provided or preauthorization is requested, whichever comes first:

- The appropriate government agency has not approved the procedure for your condition as required by law, or has approved it only for investigational use.
- Authoritative medical or scientific literature (such as medical journals/textbooks and government or industry reports) shows the procedure is undergoing clinical trials or experts agree studies or clinical trials are needed to determine the maximum dose, toxicity, safety, efficacy or relative efficacy compared to other procedures available for your condition. (Experts are professionals or organizations recognized as proficient in the scientific rationale for a treatment, the clinical care of patients undergoing the treatment or the logical design of clinical research to demonstrate efficacy for new treatments.)
- The provider has not shown proficiency in the procedure, based on experience and satisfactory outcomes in an acceptable number of cases.

Formulary. The plans' authorized list of generic and brand-name prescription drugs approved for use by the FDA (Food and Drug Administration).

Generic Drugs. Medications that are not trademark drugs, but are chemically equivalent to the brand-name drug.

Hospice. A private or public agency or organization with a hospice agency license that administers or provides hospice care.

Hospital. An institution licensed by the state, and — for compensation on behalf of its patients and on an inpatient basis — primarily engaged in providing diagnostic and therapeutic facilities for surgical and/or medical diagnosis treatment and care of injured or ill persons by or under the supervision of a staff of physicians. The institution also continuously provides 24-hour nursing service by or under the supervision of registered nurses, or is any other licensed institution with which PacifiCare has an agreement to provide hospital services. The following are not hospitals: skilled nursing facilities, nursing homes, convalescent homes, custodial homes, health resorts, hospices or places for rest, the aged or the treatment of pulmonary tuberculosis.

Definitions (cont'd)

Legend Prescription Drugs. Prescription drugs that have an 11-digit code assigned to them by the labeler or distributor of the product under FDA regulations.

Licensed Providers. Services of licensed providers are covered if the type of provider is recognized by this plan and is licensed in the state of Washington to provide the services you receive.

Types of providers not recognized by this plan are identified throughout this booklet. If you have a question about whether a type of provider is covered, call PacifiCare directly at 1-800-932-3004 or 206-340-1510.

Lifetime Maximum. The maximum benefit amount a plan participant may receive under the PacifiCare Choice Plan and all prior PacifiCare plans in his or her lifetime.

Medical Group. The providers to which you may be referred by your primary care provider.

Medically Necessary. Health care services, supplies, treatment or settings considered necessary to diagnose or treat sickness or injury that are:

- Consistent with your symptoms, diagnosis and treatment
- Appropriate within standards of good medical practice
- Not solely for the convenience of the patient, physician or provider
- The least costly of available, adequate alternatives (when you are an inpatient, it further means the item cannot be provided safely on an outpatient basis without adverse effect).

PacifiCare reserves the right to determine whether a service, supply, treatment or setting is medically necessary. The fact a physician or other provider has prescribed, ordered, recommended or approved a service, supply, treatment or setting does not, in itself, make it medically necessary.

Mental Condition. A condition classified as such by the Diagnostic and Statistical Manual of Mental Conditions, fourth edition.

Network Provider. A person, group, organization or facility under contract with PacifiCare to furnish covered services to plan participants.

Non-Network Provider. A person, group, organization or facility not under contract with PacifiCare to furnish covered services to plan participants.

Out-of-Area Benefits. The benefits you receive if you live outside PacifiCare's service area and more than 30 miles away from the nearest available primary care provider for at least 9 months each year.

Open Enrollment. The annual period in which eligible King County employees may join a plan or change plans and add or drop family members' coverage.

PacifiCare. PacifiCare of Washington, Incorporated, a company registered in Washington state as a health care service contractor.

PCP-Directed Benefits. The benefits you receive if your primary care provider provides or coordinates your care.

Physician. A provider licensed by the state in which he or she practices as:

- Doctor of medicine or surgery
- Doctor of osteopathy
- Doctor of podiatry

- Registered nurse
- Chiropractor
- Dentist (DDS or DMD)
- Psychologist (if licensed by the state to practice psychology and in private practice).

The plans also cover providers licensed as a physician's or osteopath's assistant, certified as a nursing assistant, or licensed as a practical nurse or registered nurse's assistant, when that provider works with or is supervised by one of the above physicians.

Preauthorization. PacifiCare's approval for medical services or supplies, which is given before the patient receives them.

Prescription Drug. Any medical substance that – under the Federal Food, Drug and Cosmetic Act (as amended) – must be labeled with Caution: federal law prohibits dispensing without a prescription.

Prescription drugs that meet the other coverage requirements of these plans will not be excluded for uses other than that stated in the drug's FDA label if the drug is recognized as effective for that use by any of the following:

- Medicare
- The American Hospital Formulary Service - Drug Information, The American Medical Association Drug Evaluation, US Pharmacopoeia - Drug Information or any other authoritative standard reference identified by Medicare or the Washington state Insurance Commissioner
- The majority of relevant peer-reviewed medical literature.

Primary Care Provider (PCP). A physician under contract with PacifiCare who provides or coordinates care for plan participants who choose him or her.

Primary Hospital. The network hospital with which your primary care provider is affiliated. Your primary care provider has agreed to refer you to this hospital whenever possible.

Prosthesis. An artificial substitute to replace a missing natural body part.

Provider. A person, group, organization or facility that provides medical services, treatment, equipment, supplies or drugs. This includes the following providers regulated under Title 18 of the RCW: naturopaths, acupuncturists and massage therapists.

Referral. An approved, prior authorization by your primary care provider.

Respite Care. Time off or a break for someone who is the main caregiver for an aged, ill or disabled adult or child.

Self-Directed Benefits. The benefits you receive under the PacifiCare Choice Plan when you choose to receive benefits for covered services not provided or coordinated by a primary care provider.

Service Area. The geographic area in Washington state where PacifiCare is authorized by the Insurance Commissioner to arrange for covered services through agreements with plan providers.

Skilled Nursing Facility. A facility that provides room and board as well as skilled nursing care 24 hours a day and is accredited as an extended care facility or is Medicare-certified as a skilled nursing facility. It is not a hotel, motel, or place for rest or domiciliary care for the aged.

Definitions (cont'd)

Temporary Employee. An employee in any position other than a regular position.

Temporomandibular Joint (TMJ) Disorders. The temporomandibular joint connects the mandible, or jawbone, to the temporal bone of the skull. TMJ disorders include those with any of the following characteristics:

- Pain in the musculature associated with the TMJ
- Internal derangements of the TMJ
- Arthritic problems with the TMJ
- Abnormal range of motion or limited range of motion of the TMJ.

Urgent Care. Care for a condition that is not life threatening but requires immediate medical attention.

Usual, Customary and Reasonable Amounts (UCR). The rates typically charged for comparable medical services provided by health care professionals in a given region with similar training and experience. UCR rates are updated every 6 months to reflect any changes due to inflation or other reasons.

If you see a network provider under the PacifiCare Choice Plan or PacifiCare Health Management Option, you will not be charged more than UCR amounts. If you see a non-network provider under the PacifiCare Choice Plan, the plan pays benefits up to UCR amounts. You will be responsible for paying any expenses that exceed UCR amounts. Expenses over UCR amounts do not apply to your out-of-pocket maximum.

Women's Health Care Services. Includes the following health care services:

- Maternity care
- Reproductive health services
- Gynecological care.

Participant Bill of Rights

Your medical coverage under these plans is through PacifiCare of Washington, Inc. (PacifiCare), a health care service contractor. Please take the time to read this booklet so you can get to know the benefits the plans offer.

As a PacifiCare plan participant, you have certain rights – refer to your “Important Facts” booklet for more information.

If you have questions about your benefits call or write PacifiCare at:

PacifiCare of Washington

PO Box 3005

Hillsboro OR 97123-3005

1-800-932-3004

Timely Problem Resolution

As a member of PacifiCare, you have the right to:

- Make complaints and appeals without discrimination and expect problems to be fairly examined and appropriately addressed.
- Responsiveness to reasonable requests made for services.

As a member of PacifiCare, you have the ***responsibility*** to:

- Provide your primary care provider or other care providers the information needed in order to care for you.
- Do your part to improve your own health condition by following treatment plans, instructions and care that you have agreed on with your provider(s).
- Behave in a manner that supports the care provided to other patients and the general functioning of the facility.
- Accept the financial responsibility associated with services received while under the care of a provider or while a patient at a facility.
- Review information regarding covered services, policies and procedures as stated in your Work & Life benefit guide.
- Ask questions of your primary care provider or PacifiCare. If you have a suggestion, concern, or a payment issue, we recommend you call customer service at 1-800-932-3004.

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